FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045435

Facility Name: St James Manor & Villa

Address: 1251 East Richton Road (Number) Crete (City) 60417 (Zip Code)

County: Will

Telephone Number: (708)672-6700 **Fax #** (708)672-4939

IDPA ID Number: 35-1124441004

Date of Initial License for Current Owners: 04/16/2000

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501 (c) 3

In the event there are further questions about this report, please contact:
Name: Richard D. Truesdale **Telephone Number:** (630)243-3480

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2001 to June 30, 2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) November 8, 2002 (Date)
(Type or Print Name) Dianne Strutynski
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	71	Sheltered Care (SC)	71	25,915	5
6		ICF/DD 16 or Less			6
7	181	TOTALS	181	66,065	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	389	350	5,124	5,863	8
9	SNF/PED					9
10	ICF	11,260	17,219		28,479	10
11	ICF/DD					11
12	SC		21,225		21,225	12
13	DD 16 OR LESS					13
14	TOTALS	11,649	38,794	5,124	55,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.11%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 04/16/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/16/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 23 and days of care provided 5,124

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	284,852	33,996	16,844	335,692		335,692		335,692			1
2	Food Purchase		266,404		266,404	(5,475)	260,929		260,929			2
3	Housekeeping	248,695	37,383	16,824	302,902		302,902		302,902			3
4	Laundry	26,272	7,015	38,666	71,953		71,953		71,953			4
5	Heat and Other Utilities			295,969	295,969		295,969		295,969			5
6	Maintenance	102,959	39,388	87,254	229,601		229,601		229,601			6
7	Other (specify):*											7
8	**TOTAL General Services**	662,778	384,186	455,557	1,502,521	(5,475)	1,497,046		1,497,046			8
	B. Health Care and Programs											
9	Medical Director			21,300	21,300		21,300		21,300			9
10	Nursing and Medical Records	2,864,517	290,159	178,150	3,332,826		3,332,826		3,332,826			10
10a	Therapy	97,159	13,086		110,245		110,245		110,245			10a
11	Activities	170,510	14,251	3,740	188,501		188,501		188,501			11
12	Social Services	55,248	92	2,507	57,847		57,847		57,847			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,187,434	317,588	205,697	3,710,719		3,710,719		3,710,719			16
	C. General Administration											
17	Administrative	94,300	112,844	292,560	499,704		499,704	(720)	498,984			17
18	Directors Fees											18
19	Professional Services			40,420	40,420		40,420		40,420			19
20	Dues, Fees, Subscriptions & Promotions			36,341	36,341		36,341	(17,230)	19,111			20
21	Clerical & General Office Expenses	194,311			194,311		194,311		194,311			21
22	Employee Benefits & Payroll Taxes			689,235	689,235	95,475	784,710		784,710			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			146,865	146,865	(90,000)	56,865		56,865			26
27	Other (specify):* **Bad debts**			81,568	81,568		81,568	(81,568)				27
28	**TOTAL General Administration**	288,611	112,844	1,286,989	1,688,444	5,475	1,693,919	(99,518)	1,594,401			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,138,823	814,618	1,948,243	6,901,684		6,901,684	(99,518)	6,802,166			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St James Manor & Villa #0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			540,674	540,674		540,674	3,176	543,850			30
31	Amortization of Pre-Op. & Org.			14,440	14,440		14,440		14,440			31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			555,114	555,114		555,114	3,176	558,290			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	19,661	236,325	298,208	554,194		554,194		554,194			39
40	Barber and Beauty Shops	1,004		27,161	28,165		28,165		28,165			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,759	60,759		60,759		60,759			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	20,665	236,325	386,128	643,118		643,118		643,118			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,159,488	1,050,943	2,889,485	8,099,916		8,099,916	(96,342)	8,003,574			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

St James Manor & Villa
0045435
COST REPORT RECLASSIFICATIONS
July 1, 2001
June 30, 2002

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	5,475	
2	FOOD		5,475

To reclass cost of employee meals from raw food to employee benefits

22	Employee benefits	90,000	
26	Insurance - Prop Liab Malpractice		90,000

To reclass cost of workers comp insurance expense

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,176	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(720)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,568)	27		24
25	Fund Raising, Advertising and Promotional	(17,230)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,342)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (96,342)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs		x	234,287	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 234,287		47

STATE OF ILLINOIS

St James Manor & Villa

ID# 0045435

Report Period Beginning: July 1, 2001

Ending: June 30, 2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(720)	0	0	0	0	0	0	0	0	0	0	(720)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(17,230)	0	0	0	0	0	0	0	0	0	0	(17,230)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(81,568)	0	0	0	0	0	0	0	0	0	0	(81,568)	27
28	**TOTAL General Administration**	(99,518)	0	0	0	0	0	0	0	0	0	0	(99,518)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(99,518)	0	0	0	0	0	0	0	0	0	0	(99,518)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number St James Manor & Villa **#** 0045435 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,176	0	0	0	0	0	0	0	0	0	0	3,176	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,176	0	0	0	0	0	0	0	0	0	0	3,176	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(96,342)	0	0	0	0	0	0	0	0	0	0	(96,342)	45

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
St. James Manor and Villas	100	Addolorata Villa	Wheeling, Il	Franciscan Village	Lemont, Il	Retirement Comm
		St. Joseph Home	Chicago, Il	Franciscan Sisters of Chicago		
		Mother Theresa Home	Lemont, Il		Lemont, Il	Religious Congregat
		Franciscan Homes and Community Services	Crownt Pt, In	Franciscan Sisters of Chicago Service Corp		
		George Davis Manor	Lafatette, In		Homewood, Il	Corp Management
		St. Elizabeth Health Center	Delphi, In	Franciscan Communities Home Care		
		St. Clare Health Center	Otterbein, In		Lemont, Il	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Sisters Services	$ 22,345	Franciscan Sisters of Chicago	0.00%	$ 22,345	$	1
2	V		Regional Mgmt Services	214,538	Franciscan Village Regional Office	0.00%	214,538		2
3	V		Corporate IT Fees	43,000	Franciscan Sisters of Chicago Service Corp	0.00%	43,000		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 279,883			$ 279,883	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number St James Manor & Villa 4 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
St. James Manor and Villas	100	St. Mary's Healthcare Center	Lafayette, In	Franciscan Home Care	Crown Pt, In	Home Health
		Franciscan Healthcare Center	Louisville, Ky	St. Anthony Home	Crown Pt, In	Hospice
		Mount Alvernia Home	Peyton, Oh	Madonna High School	Chicago, Il	School
				Marian Village	Homer Glen, Il	Retirement Comm
				St. Jude Home	Crown Pt, In	Womans' shelter

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Differences/ Adjustments for Related Organization Costs (7 minus 4)	
1	V		$			$	$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$			$	$ *	14

* Total must agree with the amount recorded on line 24 of Schedule VI.

Sum_6

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

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Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

Board Member	Position	Address	Phone	Ownership in entity that conducted business with this nursing home
Sister Franicis Clare Radke	Chair	14700 Main Street, Lemont, IL 60439	630-257-7777	NONE
Len Wychocki	Pres/CEO	1055 W. 175th St. Homewood, IL 60430	708-647-6982	NONE
Wally Garbarczyk	Director	1055 W. 175th St. Homewood, IL 60430	708-647-6982	NONE
Sr. M. Francine Labus	Director	14700 Main Street, Lemont, IL 60439	630-257-7777	NONE
Sr. Jean Marie Toriskie	Director	4055 W. Belmont Ave, Chicago, IL 60641	773-202-0310	NONE
Barry Cesafsky	Director	914 S. Bodin, Hinsdale, IL 60521	312-782-3113	NONE
Sr. Diane Marie Collins	Director	5650 Independence Apt 3E, Oak Forest, Il 60452	708-535-9293	NONE
Chester Labus	Treasurer	1055 W. 175th St. Homewood, IL 60430	708-647-6500	NONE
Tracy Cita	Secretary	1055 W. 175th St. Homewood, IL 60430	708-647-6500	NONE

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ None		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Franciscan Sisters of Chicago
Street Address: 1260 Franciscan Drive
City / State / Zip Code: Lemont, Il 60439
Phone Number: ((630)257-3987
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Sisters Services	Direct Allocation	1		$ 22,345	$	1	$ 22,345	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 22,345	$		$ 22,345	25

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Franciscan Village Regional Office
Street Address: 1260 Franciscan Drive
City / State / Zip Code: Lemont, Il 60439
Phone Number: ((630)243-2244
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Regional Mgmt Services	Direct allocation	1		$ 214,538	$	1	$ 214,538	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 214,538	$		$ 214,538	25

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Franciscan Sisters of Chicago Service Corp
Street Address: 1055 West 175th Street, Suite 202
City / State / Zip Code: Homewood, Il 60430
Phone Number: ((708)647-6500
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Corporate IT Fees	Direct Allocation	1		$ 43,000	$	1	$ 43,000	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 43,000	$		$ 43,000	25

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ None	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ None	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Manor & Villa COUNTY Will

FACILITY IDPH LICENSE NUMBER 0045435

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ None	$ None

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,658 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2000	$ 200,000	1
2					2
3	TOTALS			$ 200,000	3

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	181		2000	1979	$ 4,082,381	$ 140,772	29	$ 140,772	$ (0)	$ 305,006	4
5			2000	1998	5,422,619	142,701	38	142,701	(1)	292,266	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1988	68,448	13,690	5	13,690	(0)	28,902	9
10	Land Improvements			1988	19,973	3,995	5	3,995	(0)	7,990	10
11	Land Improvements			1988	48,579	6,940	7	6,940	(0)	13,880	11
12	Trees			2000	9,150	458	20	458	(1)	687	12
13	Facility sign			2001	20,887	1,044	20	1,044	0	1,566	13
14	Roof repair			2000	4,185	279	15	279		419	14
15	Phone system			2000	22,104	2,438	5	4,421	1,983	6,631	15
16	Phone system			2001	27,600	6,705	5	5,520	(1,185)	9,549	16
17	Water softener			2000	10,000	1,000	10	1,000		1,500	17
18	Boiler			2001	17,665	883	10	1,767	884	2,650	18
19											19
20	Plumbing			2001	2,110	211	5	211		211	20
21	Amp test switch			2001	810	81	5	81		81	21
22	Flashing			2001	1,750	175	5	175		175	22
23	Villa Entrance Landscaping			2002	3,590	359	5	359		359	23
24	Tuckpointing			2001	1,800	60	15	60		60	24
25	Nourishment room renovation			2001	8,427	281	15	281	(0)	281	25
26	Masonary - facility sign			2002	16,550	552	15	552	(0)	552	26
27	Elevator			2002	122,522	4,084	15	4,084	0	4,084	27
28	HVAC			2002	22,649	755	15	755	(0)	755	28
29	Conference room renovation			2002	15,981	533	15	533	(0)	533	29
30	Tuckpointing			2002	6,650	207	15	222	15	222	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,956,430	$ 328,203		$ 329,897	$ 1,694	$ 678,359	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 653,125	$ 198,713	$ 198,713	$		$ 418,960	71
72	Current Year Purchases	112,206	9,568	11,221	1,653		11,221	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 765,331	$ 208,281	$ 209,934	$ 1,653		$ 430,181	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility use	Chevy van	2000	$ 20,093	$ 4,190	$ 4,019	$ (171)		$ 6,028	76
77										77
78										78
79										79
80	TOTALS			$ 20,093	$ 4,190	$ 4,019	$ (171)		$ 6,028	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,941,854	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 540,674	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 543,850	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,176	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,114,568	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 55,129 Description: Mattresses, wheelchairs, oxygen concetrators and other
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ None	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		369 hrs	$ 9,831	2,261	$ 133,839	$ 2,038	2,630	$ 145,708	1
2	Licensed Speech and Language Development Therapist		hrs		69	5,432		69	5,432	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		369 hrs	9,831	2,605	153,221		2,974	163,052	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				234,287		234,287	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 19,662	4,935	$ 292,492	$ 236,325	5,673	$ 548,479	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 641,229	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,649,302		3
4	Supply Inventory (priced at)	50,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	42,257		6
7	Other Prepaid Expenses	100		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,382,888	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	375,297		13
14	Buildings, at Historical Cost	9,757,431		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	809,126		16
17	Accumulated Depreciation (book methods)	(1,108,993)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill	257,520		22
23	Other(specify): CSV and other	18,821		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,109,202	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,492,090	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 503,820	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,334		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to affiliates	1,488,302		36
37	Due to third parties	20,499		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,087,955	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,087,955	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,404,135	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,492,090	$	48

***(See instructions.)**

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,871,401	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,871,401	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(467,264)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (467,264)	17
	B. Transfers (Itemize):		
18	**Rounding**	(2)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,404,135	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,721,975	1
2	Discounts and Allowances for all Levels	(27,013)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,694,962	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	394,520	6
7	Oxygen	5,363	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 399,883	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	27,723	12
13	Barber and Beauty Care	25,524	13
14	Non-Patient Meals	7,708	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	209,496	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,107	19
20	Radiology and X-Ray		20
21	Other Medical Services	182,146	21
22	Laundry	18,515	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 510,219	23
	D. Non-Operating Revenue		
24	Contributions	1,508	24
25	Interest and Other Investment Income***	9,647	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,155	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Insurance, refunds, etc	16,433	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,433	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,632,652	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,502,521	31
32	Health Care	3,710,719	32
33	General Administration	1,688,444	33
	B. Capital Expense		
34	Ownership	555,114	34
	C. Ancillary Expense		
35	Special Cost Centers	582,359	35
36	Provider Participation Fee	60,759	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,099,916	40
41	**Income before Income Taxes (line 30 minus line 40)****	(467,264)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (467,264)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,863	2,120	$ 80,842	$ 38.13	1
2	Assistant Director of Nursing	1,880	2,080	46,035	22.13	2
3	Registered Nurses	32,403	35,908	770,551	21.46	3
4	Licensed Practical Nurses	33,301	38,099	662,264	17.38	4
5	Nurse Aides & Orderlies	103,455	112,862	1,263,028	11.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	657	737	19,661	26.68	7
8	Rehab/Therapy Aides	6,636	7,448	97,159	13.04	8
9	Activity Director	1,859	2,083	41,846	20.09	9
10	Activity Assistants	15,327	16,683	128,664	7.71	10
11	Social Service Workers	2,998	3,320	55,248	16.64	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,080	34,848	16.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,738	30,248	250,004	8.27	15
16	Dishwashers					16
17	Maintenance Workers	5,342	5,958	102,959	17.28	17
18	Housekeepers	26,368	29,083	248,695	8.55	18
19	Laundry	2,925	3,189	26,272	8.24	19
20	Administrator	1,852	2,120	94,300	44.48	20
21	Assistant Administrator					21
22	Other Administrative	1,868	2,019	31,195	15.45	22
23	Office Manager					23
24	Clerical	11,704	13,134	163,115	12.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,674	2,969	41,797	14.08	31
32	Other Health Care(specify)					32
33	Other(specify) Beauty shop			1,005		33
34	TOTAL (lines 1 - 33)	282,682	312,140	$ 4,159,488 *	$ 13.33	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 10,520	1-3	35
36	Medical Director	monthly	21,300	9-3	36
37	Medical Records Consultant	monthly	2,203	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	monthly	3,800	39-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	monthly	2,507	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 40,330		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	474	$ 20,813	10-3	50
51	Licensed Practical Nurses	1,914	67,583	10-3	51
52	Nurse Aides	2,278	46,871	10-3	52
53	TOTAL (lines 50 - 52)	4,666	$ 135,267		53

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dianne Strutynski	Exec Director	0	$ 94,300
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,300

B. Administrative - Other

Description	Amount
See attached	$ 292,560
TOTAL (agree to Schedule V, line 17, col. 3)	$ 292,560
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ernst and Young	Audit	$ 8,051
Ceridian	Payroll service	15,682
FR&R	Consulting	3,364
Various	Misc service repairs	2,020
Various	Marketing consulting	11,304
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 40,421

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,000
Unemployment Compensation Insurance	3,508
FICA Taxes	321,441
Employee Health Insurance	280,320
Employee Meals	5,475
Illinois Municipal Retirement Fund (IMRF)*	
401k retirement plan	46,932
Life insurance	23,723
Other	13,312
TOTAL (agree to Schedule V, line 22, col.8)	$ 784,711

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$ None

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,982
Health Care Worker Background Check	
(Indicate # of checks performed)	756
Dues and subscriptions	6,737
Advertising and promotion	21,866
Less: Public Relations Expense	(11,182)
Non-allowable advertising	(6,048)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,111

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ None

* Attach copy of IMRF notifications

**See instructions.

St James Manor & Villa
0045435
Administrative - Other
July 1, 2001
June 30, 2002

Regional management services	214,537.82
Employee physicals	43,000.00
Bank fees	2,923.00
Religious personnel	8,436.00
Sister services	22,345.00
Other	1,318.00
Total	292,560

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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9													
10													
11													
12													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2001 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN - 7160**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NA**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **86,792** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **60,759**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **5,475** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Ernst and Young** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Not issued at this time**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **NA**
Attach invoices and a summary of services for all architect and appraisal fees.